

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP () IE () IC	Response Timely Filed? (x) Yes () No
Requestor's Name and Address Dr. B 7125 Marvin D. Love #107 Dallas, TX 75237	MDR Tracking No.: M4-03-8163-01
	TWCC No.: _____
	Injured Employee's Name: _____
Respondent's Name and Address Dallas Area Rapid Transit Box 15	Date of Injury: _____
	Employer's Name: _____
	Insurance Carrier's No.: 00945001035

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
08/02/02	11/25/02	97139-PH	\$49.00	

PART III: REQUESTOR'S POSITION SUMMARY

Position Statement Summary dated 06/16/03 states in part, "...Our charges for procedure code 97139-PH was partially made at \$28.00; however, our usual and customary charge is \$50.00. According to TWCC, they have determined that \$35.00 was usual and customary in our area..."

PART IV: RESPONDENT'S POSITION SUMMARY

Position Statement Summary dated July 30, 2003 states in part, "...Alternatively, and in an effort to participate in the process as much as possible, self-insured responds as well as it can given the limitations of the Request. It notes that is paid all bills presented in accordance with the rules, the Act, and its contract with the HCP for treatment of the claimant's low back strain/sprain. The HCP fails to present any evidence showing that this is not the case and thus fails their burden..."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

CPT Code 97139-PH for DOS 08/02/02 denied as "00F – Fee Guideline MAR Reduction" and for DOS 11/06/02, 11/08/02, 11/21/02 and 11/25/02 denied as "111 – FHN Contract status Indicator02 – Non-contracted Provider." The requestor billed \$50.00 per date of service and the carrier paid \$28.00 for each date of service. The requestor has indicated in the Table of Disputed Services the amount in dispute is \$7.00 per date of service. Per Rule 133.307(g)(3)(D) the requestor submitted redacted EOBs showing services were reimbursed at a higher amount; therefore, reimbursement in the amount of \$35.00 is recommended.

CPT Code 97139-PH for dates of service 11/18/02 and 11/20/02 – EOBs were not submitted by either party as the EOBs submitted by the requestor were not for the injured worker named in this dispute and therefore the EOBs are not valid for this dispute. Per Rule 133.307(e)(2)(B) the requestor has not submitted convincing evidence of request for reconsideration. Additional reimbursement is not recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
08/02/02 -							
11/8/2002	97139-PH	\$21.00	\$21.00				
11/21/02 -							
11/25/2002	97139-PH	\$14.00	\$14.00				
				Total Left Column:			\$35.00
				Total Amount Due:			\$35.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of \$35.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Marguerite Foster

December 22, 2004

Authorized Signature

Typed Name

Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____